FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0016949

Facility Name: St Clara's Manor

Address: 200 Fifth Street (Number) Lincoln (City) 61938 (Zip Code)

County: Logan

Telephone Number: (217)735-1504 **Fax #** ( )

IDPA ID Number: 376075710001

Date of Initial License for Current Owners: 1972

Type of Ownership:

xx	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
xx	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: CRAIG L. ATER **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Frank Shepke
(Title) Administrator

Paid Preparer
(Signed) (Date)
(Print Name and Title) Craig L. Ater
(Firm Name & Address) Heritage Enterprises
(Telephone) (309)823-7135 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	70	Skilled (SNF)	70	25,550	1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,644	18,784	2,742	40,170	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	18,644	18,784	2,742	40,170	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.61%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 2,742

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [xx] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	233,929	22,895		256,824		256,824		256,824			1
2	Food Purchase		208,569		208,569		208,569		208,569			2
3	Housekeeping	118,330	25,852		144,182		144,182		144,182			3
4	Laundry	67,393	13,217		80,610		80,610		80,610			4
5	Heat and Other Utilities			109,587	109,587		109,587		109,587			5
6	Maintenance	60,323	54,951	31,891	147,165		147,165		147,165			6
7	Other (specify):*											7
8	**TOTAL General Services**	479,975	325,484	141,478	946,937		946,937		946,937			8
	B. Health Care and Programs											
9	Medical Director			800	800		800		800			9
10	Nursing and Medical Records	1,492,709	120,708	10,934	1,624,351		1,624,351		1,624,351			10
10a	Therapy		94,511	165,577	260,088	(134,074)	126,014		126,014			10a
11	Activities	58,022	5,894		63,916		63,916		63,916			11
12	Social Services	30,182	24	3,420	33,626		33,626		33,626			12
13	Nurse Aide Training	6,270	550		6,820		6,820		6,820			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,587,183	221,687	180,731	1,989,601	(134,074)	1,855,527		1,855,527			16
	C. General Administration											
17	Administrative	59,332			59,332		59,332		59,332			17
18	Directors Fees											18
19	Professional Services			288,670	288,670		288,670	(3,228)	285,442			19
20	Dues, Fees, Subscriptions & Promotions			106,180	106,180	(76,650)	29,530	(17,883)	11,647			20
21	Clerical & General Office Expenses	76,776	10,765	20,403	107,944		107,944		107,944			21
22	Employee Benefits & Payroll Taxes			463,635	463,635		463,635		463,635			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			3,426	3,426		3,426	(1,427)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			86,503	86,503		86,503		86,503			26
27	Other (specify):*			35,490	35,490		35,490	(35,000)	490			27
28	**TOTAL General Administration**	136,108	10,765	1,006,306	1,153,179	(76,650)	1,076,529	(57,538)	1,018,991			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,203,266	557,936	1,328,515	4,089,717	(210,724)	3,878,993	(57,538)	3,821,455			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Clara's Manor #0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			145,018	145,018		145,018		145,018			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,683	2,683		2,683	(2,683)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			899	899		899	(333)	566			35
36	Other (specify):*											36
37	**TOTAL Ownership**			148,600	148,600		148,600	(3,016)	145,584			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					134,074	134,074		134,074			39
40	Barber and Beauty Shops			13,148	13,148		13,148		13,148			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					76,650	76,650		76,650			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			13,148	13,148	210,724	223,872		223,872			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,203,266	557,936	1,490,263	4,251,465		4,251,465	(60,554)	4,190,911			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(333)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,683)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(326)	20		17
18	Fines and Penalties				18
19	Entertainment	(1,427)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,228)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(35,000)	27		24
25	Fund Raising, Advertising and Promotional	(17,557)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (60,554)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (60,554)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

St Clara's Manor

ID# 0016949

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		(333)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(326)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(3,228)	19	22
23				23
24		(35,000)	27	24
25		(17,557)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(56,444)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,228)	0	0	0	0	0	0	0	0	0	0	(3,228)	19
20	Fees, Subscriptions & Promotions	(17,883)	0	0	0	0	0	0	0	0	0	0	(17,883)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,427)	0	0	0	0	0	0	0	0	0	0	(1,427)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(35,000)	0	0	0	0	0	0	0	0	0	0	(35,000)	27
28	**TOTAL General Administration**	(57,538)	0	0	0	0	0	0	0	0	0	0	(57,538)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(57,538)	0	0	0	0	0	0	0	0	0	0	(57,538)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number St Clara's Manor **#** 0016949 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,683)	0	0	0	0	0	0	0	0	0	0	(2,683)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(333)	0	0	0	0	0	0	0	0	0	0	(333)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,016)	0	0	0	0	0	0	0	0	0	0	(3,016)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,554)	0	0	0	0	0	0	0	0	0	0	(60,554)	45

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	St. Clara Endowment Fund	xx		Equipment Purchase			$	$ 185,720		0.0400	$ 2,683	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 185,720			$ 2,683	9
	B. Non-Facility Related*											
10	Interest Income										(2,683)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (2,683)	14
15	TOTALS (line 9+line14)						$	$ 185,720			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME St Clara's Manor COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0016949

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☐ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 38,660	1
2					2
3	TOTALS			$ 38,660	3

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	140				$ 1,624,882	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1976			1976	65,361						9
10	1978			1978	3,451						10
11	1980			1980	8,793						11
12	1981			1981	11,439						12
13	1982			1982	3,826						13
14	1983			1983	1,535						14
15	1984			1984	4,031						15
16	1985			1985	7,859						16
17	1986			1986	2,541						17
18	1987			1987	10,753						18
19	1988			1988	1,006						19
20	1989			1989	1,431						20
21	1991			1991	8,799						21
22	1992			1992	17,963						22
23	1993			1993	15,564						23
24	1994			1994	51,022						24
25	1995			1995	124,932						25
26	1996			1996	102,380						26
27	1997			1997	39,247						27
28	Fire Sprinkler			1998	22,151						28
29	Transfer Switch			1998	4,819						29
30	Water Line			1998	6,379						30
31	Soffits			1998	3,950						31
32	Generator			1998	3,164						32
33	Heating, A/C Improvements			1998	8,664						33
34	C/O Allocation										34
35	Book Depreciation					83,124		83,124		1,637,222	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Windows	1998	$ 3,422	$		$	$	$	37
38	Sidewalks	1998	2,963						38
39	Fixtures	1999	224						39
40	Faucets	1999	1,532						40
41	Water System Improvements	1999	7,920						41
42	Windows	1999	23,400						42
43	Fixtures	1999	2,812						43
44	Faucets	1999	1,404						44
45	Heating & Cooling Unit	2000	4,050						45
46	Water System	2000	37,203						46
47	Glass Doors	2000	1,145						47
48	Remodeling	2000	4,581						48
49	Plumbing	2000	4,128						49
50	Windows	2000	600						50
51	Plumbing	2000	1,702						51
52	4 Ton Condensing Unit	2000	4,453						52
53	Windows	2000	5,400						53
54	Exhaust Fan	2000	1,100						54
55	Heating & Cooling Units	2000	4,050						55
56	Doors	2000	4,081						56
57	Porch Ceiling	2000	4,050						57
58	Exhaust Fan	2000	2,046						58
59	Concrete Pad	2000	5,398						59
60	Fire Sprinkler	2001	1,304						60
61	Faucets	2001	3,432						61
62	Patio Roof	2001	1,532						62
63	Exhaust Fan	2001	1,000						63
64	A/C Unit	2001	16,312						64
65	A/C Kitchen	2001	6,850						65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,314,036	$ 83,124		$ 83,124	$	$ 1,637,222	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,314,036	$ 83,124		$ 83,124	$	$ 1,637,222	1
2									2
3	Code Alert Alarm	2002	5,600						3
4	Ceiling Fan	2002	996						4
5	Heat Cool Units	2002	4,550						5
6	Carpet	2002	2,361						6
7	Seal Coat Parking Lot	2002	3,342						7
8	Walk-In Cooler	2002	17,518						8
9	Roof Replacement	2002	92,577						9
10	Door	2002	824						10
11	Wide Area Network Wiring	2002	3,167						11
12									12
13	Roof Replacement	2003	53,524						13
14	Facility Wiring	2003	11,041						14
15	Remodel Bathrooms	2003	33,616						15
16	Closet Doors	2003	4,188						16
17	Water Heaters and Storage Tank	2003	38,929						17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,586,269	$ 83,124		$ 83,124	$	$ 1,637,222	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,036,142	$ 61,894	$ 61,894	$		$ 810,323	71
72	Current Year Purchases	8,194						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,044,336	$ 61,894	$ 61,894	$		$ 810,323	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$ 19,814	$	$	$		$	76
77				54,279						77
78										78
79										79
80	TOTALS			$ 74,093	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,743,358	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 145,018	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 145,018	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,447,545	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 566 Description: pager, computer equipment
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		550		550
3	Classroom Wages (a)		6,270		6,270
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 6,820	$	$ 6,820
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,820			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$ 44,684	$		$ 44,684	1
2	Licensed Speech and Language Development Therapist		hrs			9,887			9,887	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			70,407	1,036		71,443	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				93,475		93,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					40,599			40,599	13
14	TOTAL			$		$ 165,577	$ 94,511		$ 260,088	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Clara's Manor # 0016949 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,017,582	$	1
2	Cash-Patient Deposits	12,833		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	449,880		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,935		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,504,230	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	65,863		13
14	Buildings, at Historical Cost	2,548,504		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,128,990		16
17	Accumulated Depreciation (book methods)	(2,447,546)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	(185,720)		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,110,091	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,614,321	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,995	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,833		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	198,203		30
31	Accrued Taxes Payable (excluding real estate taxes)	(658)		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	629		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 440,002	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 440,002	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,174,319	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,614,321	$	48

***(See instructions.)**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,900,725	1
2	Restatements (describe):		2
3	**Adjustments**	(8,592)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,892,133	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	282,186	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 282,186	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,174,319	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,580,311	1
2	Discounts and Allowances for all Levels	(563,786)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,016,525	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	307,373	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 307,373	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,270	12
13	Barber and Beauty Care	15,617	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	185,911	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 202,798	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,310	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,310	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,533,006	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	946,937	31
32	Health Care	1,989,601	32
33	General Administration	1,153,179	33
	B. Capital Expense		
34	Ownership	148,600	34
	C. Ancillary Expense		
35	Special Cost Centers	13,148	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		(645)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,250,820	40
41	**Income before Income Taxes (line 30 minus line 40)****	282,186	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 282,186	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,192	$ 65,034	$ 29.67	1
2	Assistant Director of Nursing	1,968	2,080	57,501	27.64	2
3	Registered Nurses	2,565	2,654	54,728	20.62	3
4	Licensed Practical Nurses	27,718	29,431	457,545	15.55	4
5	Nurse Aides & Orderlies	82,035	86,656	813,991	9.39	5
6	Nurse Aide Trainees	1,000	1,000	6,270	6.27	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,124	2,250	43,910	19.52	8
9	Activity Director					9
10	Activity Assistants	6,576	7,228	58,022	8.03	10
11	Social Service Workers	2,000	2,113	30,182	14.28	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	29,846	31,329	233,929	7.47	15
16	Dishwashers					16
17	Maintenance Workers	6,322	6,674	60,323	9.04	17
18	Housekeepers	15,798	17,143	118,330	6.90	18
19	Laundry	8,587	9,174	67,393	7.35	19
20	Administrator	2,080	2,080	59,332	28.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,855	6,364	76,776	12.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,474	208,368	$ 2,203,266 *	$ 10.57	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		800		36
37	Medical Records Consultant		4,753		37
38	Nurse Consultant				38
39	Pharmacist Consultant		500		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,420		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,473		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides	133	2,655		52
53	TOTAL (lines 50 - 52)	133	$ 2,655		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Frank Shepky	Admin	0	$ 59,332
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,332

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 271,667
Abbott & co	Audit	13,400
Gardner & White	Pension Plan	375
		0
Legal Fees (Adjusted to zero)		3,228
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 288,670

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,901
Unemployment Compensation Insurance	15,825
FICA Taxes	168,550
Employee Health Insurance	149,630
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	101,729
Employee Benefits - central office	
TOTAL (agree to Schedule V, line 22, col.8)	$ 463,635

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	708
Health Care Worker Background Check	
(Indicate # of checks performed)	350
Central Office Allocation	
Promotional Advertising	12,205
Public Relations	5,352
Dues and Subscriptions	5,812
License and Fees	5,103
Less: Public Relations Expense	(5,352)
Non-allowable advertising	(326)
Yellow page advertising	(12,205)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,647

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,251
	27
Seminar Expense	1,148
Non Allowable	(1,427)
Central Office Allocation	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Clara's Manor # 0016949 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **No** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **829**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Pellman & Dold** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain. **Not Complete as of this date**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number			Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount							
1009			PETTY CASH	1,017,582						1,009	1010	CASH IN B	1,017,582			
1010			CASH IN BANK							1,100			449,880			
1040			CASH IN BANK-PAYROLL							1,101						
1100			ACCOUNTS RECEIVABLE	449,880						1,110						
1110			MEDICARE RECEIVABLES							1,125						
1125			IPA INCOME RECEIVABLE							1,135						
1130			MEDICARE COST REPORT							1,140						
1135			ACCOUNTS RECEIVABLE-IC							1,145						
1140			UNAPPLIED CASH RECEIPTS							1,200			23,935			
1145			A/R SUSPENSE-REFUNDS							1,220						
1190			ACCRUED INTEREST REC							1,300						
1200			PREPAID INSURANCE	23,935						1,310						
1220			OTHER PREPAID EXPENSES							1,320						
1300			FOOD INVENTORY							1,409			65,863			
1310			SUPPLIES INVENTORY							1,450			1,128,990			
1409			LAND	65,863						1,460			-810,324			
1450			FURNITURE & EQUIPMENT	1,128,990						1,475			2,548,504			
1460			ACCUM DEPR-FURN & EQUIP	-810,324						1,490			-1,637,222			
1475			BUILDING & IMPROVEMENTS	2,548,504						1,530			12,833			
1490			ACCUM DEPR-BUILDING	-1,637,222						1,550						
1530			RESIDENT FUNDS	12,833						1,551						
1550			LOAN FEES	0						1,850			-185,720			
1560			REAL ESTATE TAX ESCROW							2,010			-228,995			
1575			REIMBURSABLE PURCHASES							2,100						
1850			INTRACOMPANY	-185,720						2,100			-112,846			
2010			ACCOUNTS PAYABLE	-228,995						2,100						
2095			BONUSES PAYABLE							2,100						
2100			ACCRUED PAYROLL	-112,846						2,110			-85,357			
2110			ACCRUED VACATION PAY	-85,357						2,120						
2120			UC TAXES PAYABLE							2,125			658			
2125			FICA TAX PAYABLE	658	658					2,130						
2130			FIT PAYABLE							2,140						
2140			STATE W/H PAYABLE		0					2,152						
2145			EARNED INCOME CREDIT							2,225						
2150			UC FED CREDIT REDUCTION							2,230						
2230			PAYROLL SAVINGS							2,235						
2235			IRA W/HOLDINGS							2,240						
2240			UNITED WAY							2,246						
2245			GROUP INSURANCE PAYABLE							2,250						
2246			GROUP INSURANCE PAYABLE-CAFETERIA							2,260						
2260			WAGE GARNISHMENTS							2,300			-629			
2280			MISC PAYROLL DEDUCTIONS							2,320						
2300			ACCRUED INTEREST PAYABLE	-629						2,350						
2310			SALES TAX PAYABLE							2,385						
2320			IPA PAYMENTS PAYABLE	0						2,400						
2350			REAL ESTATE TAX PAYABLE	0						2,512			-12,833			
2385			ACTIVITY FUND	0						2,600						
2390			SECURITY DEPOSITS							2,600						
2391			VOLUNTEER FUND							2,625						
2393			HEART FUND/BAZAAR							2,625						
2395			DEFERRED INC EMP & MEM							2,695						
2400			CURRENT PORTION LT DEBT							2,720			-1,892,133			
2460			INCOME TAXES PAYABLE									net income	-282,186			
2512			DUE TO RESIDENTS	-12,833												
2600			MORTGAGE PAYABLE	0												
2650			EQUIPMENT LOAN PAYABLE									balance	0			
2695			CURRENT PORTION LT DEBT													
2696			DEFERRED INCOME TAXES													
2710			COMMON STOCK													
2720			RETAINED EARNINGS	-1,892,133												
2970			PROFIT/LOSS FOR PERIOD	-282,186												
3007.1			PATIENT DAYS-PRIVATE	18,965										3,007		18,965
3007.2			PATIENT DAYS-IPA	18,644										3,007		18,644
3007.3			PATIENT DAYS-MEDICARE	2,742										3,007		2,742
3007.4			PATIENT DAYS-CONVERSION											3,007		
3007.5			PATIENT DAYS-LICENSED											3,007		
3007.6			PATIENT DAYS-TOTAL											3,007		
3010		1	BASIC CHARGE-PRIVATE & VA	-2,281,741		0	0	0	0					3,007		
3015		1	PRIVATE ASSESSMENT TAX INCOME			0	0	0	0					3,010	3,010 BASIC CH	(2,281,741)
3020		1	BASIC CHARGE-IPA	-1,431,092		0	0	0	0					3,020	3,020 BASIC CH	(1,431,092)
3030		1	BASIC CHARGE-MEDICARE	-669,734		0	0	0	0					3,030	3,030 BASIC CH	(669,734)
3035		4	DAY CARE/HOME CARE			0	0	0	0					3,040		
3040		1	LIGHT NURSING CARE	0		0	0	0	0					3,050		
3050		1	MEDIUM NURSING CARE			0	0	0	0					3,060		
3060		1	HEAVY NURSING CARE			0	0	0	0					3,061		
3061		1	SKILLED NURSING CARE											3,080	3,080 NURSING	(73,995)
3080		1	NURSING SUPPLIES-PRIVATE	-197,867		0	0	0	0					3,081	3,081 NURSING	(96,174)
3081		1	NURSING SUPPLIES-IPA			0	0	0	0					3,082	3,082 NURSING	(27,698)
3082		1	NURSING SUPPLIES MED PT A			0	0	0	0					3,083		
3083		1	NURSING SUPPLIES MED PT B											3,100	3,100 DRUGS-MI	(185,911)
3100		17	DRUGS	-185,911		0	0	0	0					3,101		
3101		17	DRUGS-OTHER											3,110	3,110 PHYSICAL	(8,920)
3110		6	PT-PRIVATE	-307,373		0	0	0	0					3,111	3,111 PHYSICAL	(1,010)
3111		6	PT-IPA			0	0	0	0					3,112	3,112 PHYSICAL	(104,700)
3112		6	PT-MEDICARE PART A			0	0	0	0					3,113	3,113 PHYSICAL	(15,449)
3113		6	PT-MEDICARE PART B			0	0	0	0					3,140	3,140 LABORAT	(64,547)
3130		1	PUBLIC AID ASSESSMENT INC											3,150	3,150 ST/OT THE	(10,080)
3140		19	LABORATORY INCOME			0	0	0	0					3,151	3,151 ST/OT THE	(1,112)
3150		6	SPEECH/OT-PRIVATE			0	0	0	0					3,152	3,152 ST/OT THE	(65,220)
3151		6	SPEECH/OT-IPA			0	0	0	0					3,153	3,153 ST/OT THE	(17,535)
3152		6	SPEECH/OT-MED PART A			0	0	0	0					3,160	3,160 X-RAY SEI	(18,800)
3153		6	SPEECH/OT MED PART B											3,410	3,410 IPA/OTHEI	84,527
3410		2	IPA DISCOUNTS	563,786		0	0	0	0					3,411	3,411 MEDICARI	11,588
3411		2	MEDICAID PART B DISCOUNT			0	0	0	0					3,420	3,420 MEDICARI	466,559
3420		2	MEDICARE DISCOUNTS			0	0	0	0					3,500		
3440		36	ASSESSMENT TAX EXPENSE			42	3	0	0					3,520	3,525 CONTRIBU	0
3520		16	RENT INCOME	0		6	0	6	0					3,530	3,530 BEAUTY S	(15,617)
3530		13	BEAUTY SHOP	-15,617		0	0	0	0					3,560	3,560 ACTIVITY	(407)
3560		12	ACTIVITY FUND INCOME	-407		0	0	0	0					3,570	3,570 VENDING	(863)
3570		12	VENDING INCOME/EXPENSE	-863		0	0	0	0					3,590	3,590 EQUIPMEN	123
3580		12	MANAGEMENT FEES			0	0	0	0					3,595		
3590		1	EQUIPMENT RENTAL	123		0	0	0	0					3,600		
3595		21	RESIDENT TRANSPORTATION	0		0	0	0	0					4,110	4,110 G&A WAG	76,776
3600		21	MISC INCOME	0		0	0	0	0					4,111	4,111 ADMINIST	59,332
4110			GENERAL & ADMINIST WAGES	76,776	76,776	21	1	17	0					4,115		
4111			ADMINISTRATOR WAGES	59,332	59,332	17	1	0	0					4,120	4,120 EMPLOYE	101,384
4115			VACATION & SICK - G&A	0		21	1	0	0					4,125		
4120	4475		EMPLOYEE BENEFITS	101,729	463,635	22	3	0	0					4,130		
4125			EMPLOYEE HEPETITIS VACCIN	0		22	3	0	0					4,135		
4130			EMPLOYEE SCHOLORSHIP WA(	0		21	1	0	0					4,250	4,250 OFFICE SU	6,256
4135			EMPLOYEE SCHOLORSHIP COS	0		23	3	0	0					4,255	4,255 POSTAGE	3,801
4220			DIRECTORS FEES			18	3	0	0					4,260	4,260 TELEPHO	20,403
4250	4255		OFFICE SUPPLIES	10,765	10,765	21	2	0	0					4,275	4,275 TRAINING	1,999
4260			TELEPHONE	20,403	20,403	21	3	0	0					4,276		
4275			TRAINING & EMPLOYEE DEVL	1,999	1,999	23	3	16	0					4,280	4,280 GENERAL	2,251
4280			GENERAL TRAVEL	2,251	3,426	24	3	16	0					4,281	4,281 MEAL EXF	27
4281			MEAL EXPENSE FOR TRAVEL	27		24	3	19	0					4,285	4,285 EDUCATIC	1,020
4285			EDUCATION & SEMINAR	1,148		24	3	19	-1,427 ***					4,289	4,289 MEETINGS	128
4290			HELP WANTED ADVERTISING	708	106,180	20	3	0	0	-76,650				4,290	4,290 HELP WAN	708
4291			PROMOTIONAL ADVERTISING	12,205		20	3	25	-12,205					4,291	4,291 PROMOTIC	12,205
4292			PUBLIC RELATIONS	5,352		20	3	25	-5,352					4,292	4,292 PUBLIC RI	5,352
4300			LICENSES & FEES	81,753		20	3	17	0					4,300	4,300 LICENSE &	81,753
4310			DUES & SUBSCRIPTIONS	5,812		20	3	17	-326					4,310	4,310 DUES & SU	5,812
4320			CONTRIBUTIONS	0		27	3	20	0					4,320		
4350			PROFESSIONAL FEES	17,002	288,670	19	3	22	-3,228					4,350	4,350 PROFESSIC	17,002
4355			MEDICAL DIRECTOR	800	800	9	3	0	0					4,355	4,355 MEDICAL	800
4360			UTILIZATION REVIEW			10	3	0	0					4,362	4,362 MEDICAL	4,753
4361			OTHER PHYSICIAN FEES	1,860		39	3	0	0					4,363	4,363 PHARMAC	500
4362			MEDICAL RECORDS CONSULT	4,753		10	3	0	0					4,364	4,364 SOCIAL SE	3,420
4363			PHARMACIST FEES	500		10	3	0	0					4,370	4,370 TV RENTA	720
4364			SOC SERV/ACT CONSULT	3,420	3,420	12	3	0	0					4,383	4,383 BAKCGRO	350
4370			TV RENTAL	720		35	3	5	-333					4,390		
4380			INCOME TAXES		35,490	27	3	26	0					4,400	4,400 PAYROLL	178,216
4383			BACKGROUND CHECKS	350		20	3	26	0					4,401	4,401 PAYROLL	6,159
4400			PAYROLL TAXES	178,216		22	3	0	0					4,410	4,410 GROUP IN	149,630
4401			PAYROLL TAXES ADMINIST	6,159		22	3	0	0					4,420	4,420 LIABILITY	86,503
4410			GROUP INSURANCE	149,630		22	3	0	0					4,430	4,430 WORKMA	27,901
4420			LIABILITY INSURANCE	86,503	86,503	26	3	0	0					4,435		
4425			INSURANCE-OWNERS			22	3	21	0					4,436		
4430			WORKMENS COMP INSURANCI	27,901		22	3	0	0					4,450	4,450 MANAGE	271,668
4450			CENTRAL OFFICE FEES	271,668		19	3	34	0 **					4,460	4,460 BAD DEBT	35,000
4460			BAD DEBTS	35,000		27	3	24	-35,000					4,461	4,461 BAD DEBT	1,112
4470			LOST ITEMS-RESIDENTS	490		27	3	0						4,470	4,470 LOST ITEM	490
4490			MISCELLANEOUS	0		27	3	0	0					4,475	4,475 UNIFORM	345
4510			REAL ESTATE TAXES	0	0	33	3	0	0					4,486	4,486 SERVICE (	3,514
4600			LEASED EQUIPMENT	179	899	35	3	16	0					4,490	4,490 MISC EXPI	989
5110			MAINTENANCE SALARIES	59,021	60,323	6	1	0	0					4,496	4,496 MISC. M.I.	708
5120			MAINTENANCE SICK & VAC	1,302		6	1	0	0					4,510		
5130			ELECTRIC	65,568	109,587	5	3	0	0					4,600	4,600 LEASED E	179
5131			NATURAL GAS	21,265		5	3	0	0					5,110	5,110 MAINTENA	59,021
5132			HEATING & DEISEL OIL			5	3	0	0					5,120	5,120 MAINTENA	1,302
5133			WATER & SEWER	22,754		5	3	0	0					5,130	5,130 ELECTRIC	65,568
5134			TRASH COLLECTION	4,303	31,891	6	3	0	0					5,131	5,131 NATURAL	21,265
5140			PROPERTY PLANT REPLACEMI	6,767	54,951	6	2	0	0					5,133	5,133 WATER &	22,754
5160			GENERAL REPAIR & MAINT	48,184		6	2	0	0					5,134	5,134 TRASH CO	4,303
5165			MAINTENANCE CONTRACTS	27,588		6	3	0	0					5,140	5,140 PROP/PLAI	6,767
5210			DIETARY WAGES	232,516	233,929	1	1	0	0					5,160	5,160 GENERAL	48,184
5220			DIETARY SICK & VAC	1,413		1	1	0	0					5,165	5,165 MAINTENA	24,074
5240			SALES TAX			2	3	13	0					5,210	5,210 DIETARY	232,516
5248			FOOD PURCHASES	209,398	208,569	2	2	0	0					5,220	5,220 DIETARY I	1,413
5250			SUPPLIES-DISHWASHING	7,644	22,895	1	2	0	0					5,248	5,248 FOOD PUR	208,409
5260			DIETARY REPLACEMENT	6,953		1	2	0	0					5,250	5,250 SUPPLIES	7,644
5270			KITCHEN SUPPLIES-PAPER	8,298		1	2	0	0					5,260	5,260 REPLACEI	6,953
5295			MEAL CREDIT	-829		2	2	0	0					5,270	5,270 KITCHEN	8,298
5310			LAUNDRY WAGES	67,385	67,393	4	1	0	0					5,295	5,295 MEAL INC	(829)
5340			LAUNDRY SICK & VAC	8		4	1	0	0					5,310	5,310 LAUNDRY	67,385
5370			LAUNDRY REPLACEMENT	5,789	13,217	4	2	0	0					5,340	5,340 LAUNDRY	8
5380			LAUNDRY REIMBURSEMENT			4	3	0	0					5,370	5,370 REPLACEI	5,789
5390			LAUNDRY SUPPLIES	7,428		4	2	0	0					5,380	5,380 OUTSIDE I	104
5410			HOUSEKEEPING WAGES	118,253	118,330	3	1	0	0					5,390	5,390 SUPPLIES	7,324
5440			HOUSEKEEPING SICK & VAC	77		3	1	0	0					5,410	5,410 HOUSEKE	118,253
5480			HOUSEKEEPING SUPPLIES	7,083	25,852	3	2	0	0					5,440	5,440 HOUSEKE	77
5490			HOUSEKEEPING SUPPLIES-PPR	18,769		3	2	0	0					5,480	5,480 SUPPLIES-	7,083
6010			RN WAGES-MEDICARE		1,492,709	10	1	0	0					5,490	5,490 SUPPLIES-	18,769
6020			RN WAGES-NON MEDICARE	51,812		10	1	0	0					6,020	6,020 RN WAGE	51,812
6030			DON WAGES	65,034		10	1	0	0					6,030	6,030 DON WAG	65,034
6035			ADON	57,501		10	1	0	0					6,035	6,035 ADON WA	57,501
6040			RN SICK & VACATION	2,916		10	1	0	0					6,040	6,040 RN PTO &	2,916
6110			LPN WAGES-MEDICARE			10	1	0	0					6,120	6,120 LPN WAGI	434,171
6120			LPN WAGES-NON MEDICARE	434,171		10	1	0	0					6,140	6,140 LPN PTO &	23,374
6130			LPN WAGES OTHER			10	1	0	0					6,220	6,220 AIDES WA	738,861
6140			LPN SICK & VACATION	23,374		10	1	0	0					6,240	6,240 AIDES PTC	75,130
6210			AIDE WAGES-MEDICARE			10	1	0	0					6,245		
6220			AIDE WAGES-NON MEDICARE	738,861		10	1	0	0					6,246		
6230			WARD CLERKS			10	1	0	0					6,247	6,247 CONTRAC	2,655
6240			AIDE VACATION & SICK	75,130		10	1	0	0					6,250	6,250 NURSE AII	6,270
6245			CONTRACT NURSES-RN	0		10	3	0	0					6,255	6,255 NURSE AII	550
6246			CONTRACT NURSES-LPN	0		10	3	0	0					6,260		
6247			CONTRACT NURSES-AIDES	2,655		10	3	0	0					6,270	6,270 REHAB W	42,112
6250			NURSE AIDE TRAINING WAGES	6,270	6,270	13	1	0	0					6,275	6,275 REHAB PT	1,798
6255			NURSE AID TRAINING EXP	550	550	13	2	0	0					6,290	6,290 NURSING	21,742
6260			NURSE AIDE TRAINING REIMB	0		0	0	0	0					6,295	6,295 NURSING	97,401
6270			REHAB WAGES	42,112		10	1	0	0					6,390	6,390 REPLACEI	1,565
6275			REHAB SICK & VAC	1,798		10	1	0	0					6,490	6,490 OTHER	1,166
6280			NURSING DEPT EDUCATION			23	3	0	0					7,280	7,280 DRUG PUI	93,441
6290			NURSING SUPPLIES	21,742	120,708	10	2	0	0					7,281	7,281 DRUG PUI	34
6295			NURSING SUPPLIES	97,401		10	2	0	0					7,380	7,380 LABORAT	24,212
6390			REPLACEMENT-NURSING	1,565		10	2	0	0					7,391	7,390 X-RAY SEI	14,668
6490			NURSING OTHER	1,166	10,934	10	3	0	0					7,393	7,393 OTHER A S	1,719
7280			DRUG PURCHASES	93,441	94,511	39	2	0	0 ***					7,510	7,510 ACTIVITIE	57,227
7281			DRUG PURCHASES-OTHER	34		39	2							7,540	7,540 ACTIVITIE	795
7380			LABORATORY SERVICES	40,599	165,577	39	3	0	0					7,590	7,590 ACTIVITIE	5,894
7410			HOME HEALTH SALARY			39	1	0	0					7,620	7,620 PHYSICAL	70,407
7440			HOME HEALTH SICK & VAC			39	1	0	0					7,660	7,660 P.T. SUPPL	1,036
7450			HOME HEALTH EXPENSES			39	3	0	0					7,710	7,710 SOCIAL SE	28,924
7510			ACTIVITES WAGES	57,227	58,022	11	1	0	0					7,720	7,720 SOCIAL SE	1,258
7540			ACTIVITIES SICK & VAC	795		11	1	0	0					7,730	7,730 SOCIAL SE	24
7590			ACTIVITIES SUPPLIES	5,894	5,894	11	2	0	0					7,740	7,740 OCCUPAT	44,684
7595			ACTIVITIES FEES	0	0	11	3	0	0					7,750		
7610			PT WAGES			39	1	0	0					7,770	7,770 SPEECH TI	9,887
7611			PT SICK & VACATION			39	1	0	0					7,820	7,820 BEAUTICL	13,148
7620			PT FEES	70,407		39	3	0	0 ***					7,890		
7660			PT SUPPLIES	1,036		39	2	0	0					7,960		
7710			SOCIAL SERVICE WAGES	28,924	30,182	12	1	0	0					8,120	8,120 INTEREST	2,683
7720			SOCIAL SERVICE SICK & VAC	1,258		12	1	0	0					8,125		
7730			SOCIAL SERVICE EXPENSES	24	24	12	2	0	0					8,130	8,130 DEPRECIA	145,018
7740			OT FEE	44,684		39	3	0	0 ***					8,150		
7750			SOCIAL THERAPIST FEE	0	0	12	3	0	0					9,510	9,510 INTEREST	(6,310)
7770			SPEECH THERAPY FEE	9,887		39	3	0	0 ***					9,520	9,520 CONTRIBU	(645)
7800			BEAUTICIAN WAGES		0	40	1	0	0					9,530		
7810			BEAUTICIAN SICK & VAC			40	1	0	0						4,361 OTHER PH	1,860
7820			BEAUTICIAN FEES	13,148	13,148	40	3	0	0							-284,046
7890			BEAUTY SHOP SUPPLIES	0	0	40	2	0	0							
7910			VOLUNTEER COORDINATOR			21	1	0	0							
7940			VOL COORD SICK & VAC			21	1	0	0							
7960			VOL COORD SUPPLIES	0		21	2	0	0							
8100			RENT		0	34	3	0	0							
8120			INTEREST EXPENSE	2,683	2,683	32	3	14	-2,683							
8130			DEPRECIATION	145,018	145,018	30	3	9	0							
8150			LOAN FEE AMORTIZATION	0		32	3	0	0	60,773						
9510			INTEREST INCOME	-6,310		32	0	10	0							
9520			MISC NON-OPERATING INCOM	0		0	0	0	0							
9700			INCOME TAXES	-645		0	0	0	0							
				4,244,510	4,251,465											
					6,955											
GRAND TOTALS				-282,186					-60,554							
				(NET INCOME)												
				0												

FACILITY NAME:	
FACILITY ID:	0
FACILITY UNITS:	89
BALANCE SHEET TOTAL	0
	173,113

	G/L	RECAP CENSUS
PP	18,965	18,784
IPA	18,644	18,644
medicare	2,742	2,742
		40,170

IPA BEDHOLDS	0
PP BEDHOLDS	181
PP CONVERS	0